KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
BUREAU OF DISEASE CONTROL AND PREVENTION: TUBERCULOSIS CONTROL PROGRAM

TUBERCULOSIS INFECTION AND DISEASE FORM

PLEASE TYPE OR PRINT NEATLY

COUNTY OF RESIDENCE:

Event Information: _____ Active ____ Suspect ____ TB Infection
_____ Contact to an active case

EPI TRAXNumber: _____

Name of Active Case: _____

Occupation: _____

Patient Name:_____
Last First Middle

Name of Employer/School:_____

Referral Source:_____

Day Time Phone ( )_____
Evening Phone ( )_____

Address:_____
Street/Route City/Town State Zip Code

Parent/Guardian Name: _____ **Telephone Number:** ( )_____
Last First Middle

Address:_____
Street/Route City/Town State Zip Code

Race: Mark all that apply
___ American Indian/Alaskan Native ___ Native Hawaiian/Other Pacific Islander
___ Asian ___ Race not otherwise specified
___ Black/African American ___ White

Gender:
___ Male
___ Female

Ethnicity:
___ Not Hispanic or Latino
___ Hispanic or Latino

Date of Birth:
_____/_____/_____

Country of Birth: _____USA _____ Other (specify) _____Date of Arrival: _____/_____/_____
_____ Refugee _____ Recent Immigration ____ Class B1 ____ Class B2

___ Homeless in the past year
___ Resident of a Correctional Facility at diagnosis
Inmate #_____
___ Resident of a long-term care facility at diagnosis
Name of Facility
_____

In the past year, does the patient have a history of:
_____ Alcohol abuse
_____ Non-IV drug use
_____ IV drug use

HIV Status
____Negative (Date) _____
___ Positive (Date) _____
___ Indeterminate ____ Test Done, Results Unknown
___ Patient Refused Test ____ Unknown
____ Test Not Offered

MEDICAL HISTORY (Mark all that apply)

____ Asthma ____ Pneumonia ____ Bronchitis
____ Hypertension ____ Cancer, current disease ___ Cancer, previous episode
____ Diabetes ____ Hepatitis ___ Cardiac Disease
____ Tobacco Use ____ Other_____

SYMPTOMOLOGY of TB Disease (Mark all that apply)

___ Productive Cough Date of Onset:_____/_____/_____
____ Weight Loss ____ Fever
____ Night Sweats ____ Fatigue
____ Chest Pain ____ Shortness of Breath
____ Lymphadenopathy ____ Hemoptysis
____ Hematuria

X-Ray Date: _____/_____/_____ _____Normal, Negative, or NEAD _____Abnormal
Month Day Year
If Abnormal, please attach radiological interpretation

Current Interferon Gamma Release Assay Result: Date drawn: _____/_____/_____ Date Reported: _____/_____/_____ Positive ____
Month Day Year Month Day Year Negative _____
Type of Test: Quantiferon _____ T-Spot _____ Indeterminate ____

Previous Interferon Gamma Release Assay Result: Date drawn: _____/_____/_____ Date Reported: _____/_____/_____ Positive ____
Month Day Year Month Day Year Negative _____
Type of Test: Quantiferon _____ T-Spot _____ Indeterminate ____

Current PPD Skin Test Reading: Date Planted: _____/_____/_____ Date Read: _____/_____/_____ Induration (mm): _____ Positive ____
Month Day Year Month Day Year Negative _____

Previous PPD Skin Test Reading: Date Planted: _____/_____/_____ Date Read: _____/_____/_____ Induration (mm): _____ Positive ____
Month Day Year Month Day Year Negative _____

RISK CRITERIA USED IN ESTABLISHING THE SIGNIFICANCE OF THE PPD SKIN TEST REACTION

Local Health authorities may determine that certain groups are at an increased risk for TB. Usually health care workers are considered positive at 10mm induration. Contact KDHE, or your local health department for more information.

5 mm or more	**10 mm or more**	**15 mm or more**
____ HIV Infection ____ Close Contact to a TB case ____ Fibrotic changes on CXR consistent with old TB ____ Organ Transplant ____ Other immunosuppressed patients	____ Recent arrivals from high prevalence countries ____ Injection Drug Users ____ Residents and employees of high-risk congregate settings* ____ Mycobacteriology laboratory personnel ____ Persons with clinical conditions that make them high-risk** ____ Children <4 years of age, or children and adolescents exposed to adults in high- risk categories	____ No known risk factors

***Health Occupations, or residential settings that increase the risk of TB include:**
___ Health Care Worker ___ Homeless Shelter ___ Rehabilitation Center
___ Long Term Care Facility ___ Correctional Facility ___ Mycobacteriology Lab ___ Other _____

****Medical conditions that increase the risk of TB include:**
____diabetes mellitus ____ corticosteroid therapy ____cancer of the head and neck
____ silicosis ____ immunosuppressive therapy ____chronic malabsorption.
____ end-stage renal disease ____ hematologic and reticuloendothelial diseases ____ intestinal bypass or gastrectomy ____ TNf Inhibitors

Form Updated 7/18/2013

Name: _____ Date of Birth: _____

Patient's Wt. _____lbs. _____kg. Drug Allergies: ____ No ____ Yes _____

Current Medications: _____

Discussed TB FACTS: ____ Yes ____ No Discussed medication's potential side effects or adverse effects ____ Yes ____ No

Drug Precautions/ Contraindications
___ None
____ Alcohol or drug abuse in past year
____ History of Chronic Liver Disease
____ Pregnant or breast feeding
____ Currently on medication that may cause an interaction
_____ At risk for peripheral neuropathy
_____ History of adv. reaction to TB medications

Birth Control (Females only) ____ No _____ Yes (Method) _____

Medications have been prescribed by:_____
(Physician's Name) (Telephone Number)

Physician monitoring progress of client: _____
(Physician's Name) (Telephone Number)

MEDICATIONS PRESCRIBED FOR TB INFECTION: Indicate TB Infection regiment selected and length of treatment prescribed**:**

_____

_____

____No meds prescribed (detail in notes)

Date Started: _____/_____/_____			Date Started: _____/_____/_____			End of Therapy Reason :
Drug	Dosage*	Frequency and duration**	Drug	Dosage*	Frequency and duration**	
Isoniazid			Isoniazid			
Rifampin			Rifampin			**Notes:**
Rifapentine			Rifapentine			
Vitamin B6			Vitamin B6			
Date Ended: _____/_____/_____			Date Ended: _____/_____/_____			

MEDICATIONS PRESCRIBED FOR SUSPECT OR ACTIVE TB DISEASE:

Date Started: _____/_____/_____			Date Started: _____/_____/_____			Date Started: _____/_____/_____		
Drug	Dosage*	Frequency**	Drug	Dosage*	Frequency**	Drug	Dosage*	Frequency**
Isoniazid			Isoniazid			Isoniazid		
Rifampin			Rifampin			Rifampin		
Pyrazinamide			Pyrazinamide			Pyrazinamide		
Ethambutol			Ethambutol			Ethambutol		
Vitamin B6			Vitamin B6			Vitamin B6		
Date Ended: _____/_____/_____			Date Ended: _____/_____/_____			Date Ended: _____/_____/_____		

Notes:

*Total dosage in milligrams **Frequency of medication dosages (daily, twice weekly, thrice weekly) *NOTE: For TB Infection, include duration expected*

Document doses given on a Medication Administration Record

Patients on therapy for TB disease should be monitored daily for adverse reactions and medications are given by directly observed therapy (DOT).

Location of Direct Observed Therapy ____ Health Department ____ Client's home ___ Other _____

Name of person(s) providing DOT _____

(Print clearly)

This form completed by: _____Phone: _____

Agency: _____ Today's Date: _____

Send Form to:
Kansas Department of Health and Environment
Tuberculosis Control Program
1000 SW Jackson, Ste. 210
Topeka, KS 66612-1274

Contact Information:

Phone: 785-296-5589
Fax: 785-291-3732

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